Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005043	A. BUILDING _____ B. WING _____	09/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOSPITAL	700 BROADWAY FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State hospital complaint survey. Date: 9/27/2011 Facility Number: 005043 Complaint: IN00093056 - Unsubstantiated: Lack of sufficient evidence Surveyor: Albert Daeger, CFM, SFPIO Medical Surveyor St. Joseph Hospital is in compliance with 410 IAC 15-1.5-1, Dietetic services and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules. QA: claughlin 10/06/11	S 000		

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE